DOCUMENT RESUME

ED 242 168 EC 162 139

AUTHOR Epple, W. A.; Jacobson, J. W.
TITLE Staffing in Residential Programs: A Report on Staffing Ratios in Large State-Operated Residential Facilities for Mentally Retarded Persons in the United States. Revised.
INSTITUTION New York State Office of Mental Retardation and Developmental Disabilities, Albany. Bureau of Program Research and Planning.
PUB DATE Jan 84
NOTE 33p.
AVAILABLE FROM New York State Office of Mental Retardation and Developmental Disabilities, Bureau of Program Research and Planning, 44 Holland Ave., Albany, NY 12229.
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Administrator Role; *Mental Retardation; Paraprofessional Personnel; Personnel Data; Professional Personnel; *Residential Programs; Resource Staff; *Staff Role; Staff Utilization

ABSTRACT

A telephone survey of each state's mental retardation/developmental disabilities agency was conducted to assess the scope of public residential facility staffing nationally. Results revealed that every state had at least one large state operated residential facility, with 247 such facilities nationally. The national bed utilization rate was 4.92 per 10,000 general population. The average size of these facilities across all states was 450.7 residents, with 56.6% of the residents being profoundly retarded. Of all staff, 51.5% are in direct case and 19.9% in the clinical category. The overall staff to resident ratio was 1.60:1, with ratios for the administration staff to residents, 0.12:1, clinical staff to residents, 0.32:1; direct cast staff to residents, 0.82:1; and support staff to residents, 0.33:1. Variability in staffing patterns were thought to reflect budgetary constraints and differing staffing methodologies. (Author/CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

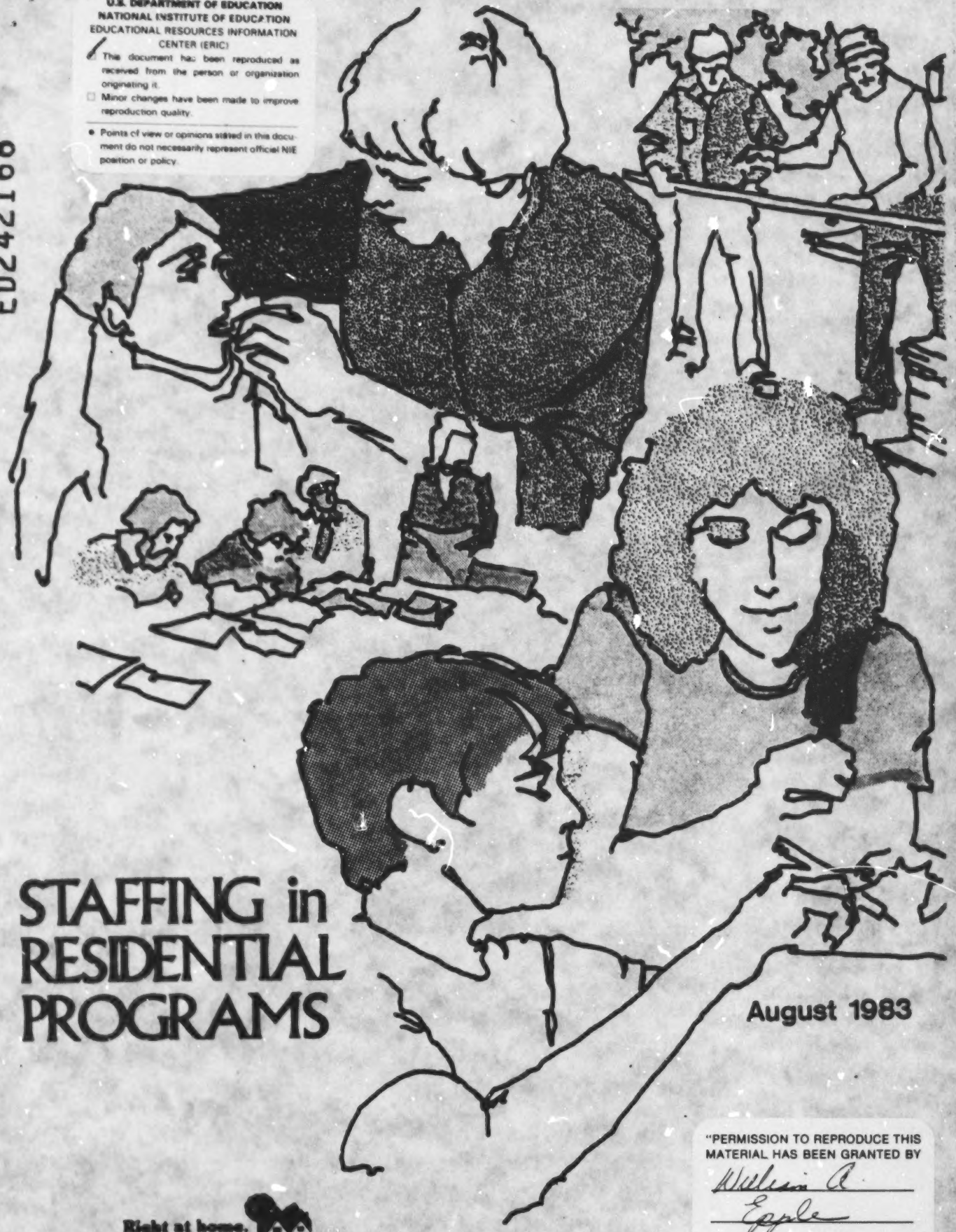
U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

ED242168



STAFFING in RESIDENTIAL PROGRAMS

August 1983

Right at home.
Right in the neighborhood.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Melissa A. Eagle

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC162139

Right at home.
Right in the neighborhood.

NEW YORK STATE OFFICE OF
MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

Arthur Y. Webb
Commissioner

Mario M. Cuomo
Governor

Arthur Y. Webb
Commissioner

Paul S. Puccio
Deputy Commissioner
for
Program Planning and Policy Analysis

Bureau of Program Research and Planning

Matthew P. Janicki, Ph.D.
Director

Note to Readers

The authors are solely responsible for the contents of this report. Every effort was made to verify information provided by state representatives. Any and all omissions or errors are the responsibility of the authors. Population referenced rates were included for comparative purposes only and should not be used to serve as a comment on the greater or lesser availability of specialized residential programs in the individual states. It is recognized that states have a variety of other alternate programs available.

Suggested Citation:

Epple, W.A. and Jacobson, J.W. Staffing in Residential Programs: A Report on Staffing Ratios in Large State-Operated Residential Facilities for Mentally Retarded Persons in the United States. Albany, New York: New York State Office of Mental Retardation and Developmental Disabilities, 1983.

For more information or additional copies of this report, please contact:

New York State Office of Mental Retardation
and Developmental Disabilities
Bureau of Program Research and Planning
44 Holland Avenue
Albany, New York 12229

(518) 474-4904

STAFFING IN RESIDENTIAL PROGRAMS: A REPORT ON STAFFING RATIOS IN LARGE STATE-OPERATED RESIDENTIAL FACILITIES FOR MENTALLY RETARDED PERSONS IN THE UNITED STATES

William A. Epple
John W. Jacobson

August, 1983
(revised 1/84)

Bureau of Program Research and Planning
Office of Mental Retardation and Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

Abstract

A telephone survey of each state's mental retardation/developmental disabilities agency was conducted in order to describe the scope of public residential facility staffing levels nationally. This was accomplished through collecting data on the number of facilities, the number of staff working in them and the number of residents living in these facilities. Four staff categories were employed: administration, clinical, direct care, and support. Residents were grouped by MR functional level into five categories: profound, severe, moderate, mild and normal/unspecified.

The survey found that every state has at least one large state operated residential facility with 247 such facilities nationally. There are a total of 111,311 persons residing in these facilities, which leads to a national bed utilization rate of 4.92 per 10,000 general population. The average size of these facilities across all states is 450.7 residents per facility. Profoundly retarded persons make up the largest share of facility residents, with 56.6% of all residents. When combined with the severe category these groups account for 79.3% of all residents.

There are a total of 177,719 staff working in public residential facilities with an average of 719.5 staff per facility nationally. Of all staff 51.5% are in the direct care category and 19.9% are in the clinical category; a total of 71.4% of all staff involved in patient care.

The overall staff:resident ratio is 1.60:1. When broken into staff categories the staff:resident ratios are as follows: administration:resident = 0.12:1; clinical:resident = 0.32:1; direct care:resident = 0.82:1; support:resident = 0.33:1.

The variability noted in staffing practices across states could reflect budgetary constraints related to state economics and legislative decisions. Staffing variability may also be attributed to differing staffing methodologies. In some states consent decrees may cause differing impacts on staffing. Staffing ratios have also been noted to be rising over the last two decades, probably due to the fact that a more seriously impaired population is now being served in public residential facilities.

Introduction

There is always an interest in and a need to know the most appropriate mix of staff and residents in all types of health care facilities. The maximization of resident care is a prime consideration in determining the number of staff which should be utilized in the care of residents in large facilities, yet this intent is necessarily tempered by budgetary considerations. The mix, or ratio, of staff and residents in public residential facilities for mentally retarded/developmentally disabled individuals is especially pertinent at this time in view of the intensity of care required by these individuals and the emphasis now placed on the provision of active treatment in such facilities.

Unfortunately, little research has been conducted regarding staffing levels and ratios in public residential facilities for mentally retarded/developmentally disabled individuals. Guidelines have been established on the federal level to guide states in trying to determine the best staffing levels for various disciplines in facilities which have been certified as intermediate care facilities for the mentally retarded (ICFs/MR--42 CFR 442(G)) (Department of Health, Education, and Welfare, 1978). These guidelines state that each facility's residential living unit must have sufficient, appropriately qualified, and adequately trained personnel to conduct a resident living program which will meet the needs of the residents in various habilitation and therapy areas and that staffing levels should be sufficient without augmentation by volunteers. Similarly, the Accreditation Council for Mental Retardation and Developmental Disabilities (ACMRDD, 1983) has formulated standards for residential facilities for mentally retarded individuals which reflect, and have been reflected in, regulations and court orders at Federal and State levels controlling the use of public funds in these facilities. In instances where court orders have not impacted upon staffing levels, incentives to achieve accreditation remain essentially limited to opportunities for states to obtain matching Federal funds to defray the costs of institutional care.

The few research studies conducted in the area of staffing ratios have largely focused upon psychiatric facilities, with overt concern for the influence of staffing levels upon patient outcomes and release rates. A higher

staff:resident ratio has been consistently reported to be associated with desirable resident outcomes (Becker, 1969; Martin & Segal, 1977) and faster release rates (Lasky & Dowling, 1971). A mathematical model for allocating staff in mental health facilities, considering budgetary constraints, was formulated by Lyons and Young (1976) who stated that it may be applicable to similar settings.

One study looking at staffing ratios in facilities for mentally retarded individuals from 1956-1966 found that increases in staff:resident ratios and the number of facilities had taken place in this time period (Division of Mental Retardation, 1968). Holland (1973) found that a higher staff:resident ratio was positively associated with desirable staff practices toward residents. Scheerenberger (1982) found an overall staff:resident ratio of 1.73:1 for budgeted items (1.47 for positions actually filled) in a survey of 282 public residential facilities for 1980-81, an improvement over similar professional staff categories for 1975-1976 (a change of from 0.12:1 to 0.26:1 for professional staff:resident ratios). A study in 1982 by the Nevada Department of Human Resources (1983) surveyed 48 states and reported an overall mean staff/resident ratio of 1.62:1 for 205 facilities. (This mean ratio, however, was obtained by simply dividing the ratios of each state by 48 states and not by using the total number of staff divided by the total number of residents.)

In order to further describe the scope of public residential facility staffing levels nationally, a survey was undertaken to determine the number of such facilities, the numbers of staff working in them (grouped into categorized job titles), the numbers of residents living in them categorized by intellectual level, and the type of facility certification existing in each state. This information was used to arrive at the resultant staff:resident ratios in several staff categories and for other analyses discussed below.

Method

Participants. The participants were representatives of each state's mental retardation/developmental disabilities agency that administered, certified, or otherwise oversaw that state's program for large residential facilities for mentally retarded/developmentally disabled individuals (Appendix A). All fifty

states and the District of Columbia were included. Canada's Province of Ontario was contacted and included for comparative purposes because of similarities to a number of states in the size and scope of its developmental disabilities system.

Procedure. Telephone interviews were conducted between April and June, 1983 with representatives of each of the fifty states' and the District of Columbia's mental retardation and developmental disabilities service agencies. Informants were the agency's representative responsible for state operated residential facilities or for information services.

January 1, 1983 was used as the standard date for the information requested. In a few instances, states provided information current to the point of the survey call, but in no case later than June, 1983. Due to states' differing capabilities to compile or maintain such information, in a few instances it was impossible to obtain precise breakdowns of resident or staff categories. For some states, it was possible only to obtain non-categorized information; however, every effort was made to obtain information which was considered reliable by the state's representative.

State agencies were requested to provide information on large state-operated residential facilities (public institutions) as indicated in the data set section below. Information on small community ICFs/MR, group homes, community residences, apartments, and foster family care settings which may be publicly operated, non-public residential care facilities, and private residential schools was excluded in the study. Consequently, data for each state do not reflect the total capacity or utilization of its specialized, developmental disabilities residential care system.

Descriptive information was collapsed into a tabular format. State data on numbers of persons in state-operated facilities were compared with numbers of staff in these facilities systemwide, within states, in order to compute staffing ratios. Facility certification information was recorded on a state-wide basis for all facilities in that state. Additionally, state data on persons in residential facilities were used to formulate a utilization rate per 10,000 general population base. State population information was drawn from the 1980 Census (Department of Commerce, 1981).

Data Set. A specifically designed interview form was used which permitted the coding of the following information:

1. The total number of large state-operated residential facilities in each state.

2. The type of certification regulations under which these facilities operate classified into the categories of ICF-MR, ACMRDD and "other".

3. The total number of individuals residing in these facilities and a breakdown of these individuals into the five categories of profound, severe, moderate, and mild mental retardation, and normal/unspecified.

4. The percentage of individuals in these facilities who occupy beds which are ICF/MR certified.

5. The total number of staff working in these residential facilities and a breakdown of these staff into the four categories of administrative, clinical, direct care and support.

6. The ideal total staff to resident staffing ratio goal, if any, which each state is attempting to achieve.

7. The actual total staff to resident staffing ratio systemwide in each state.

8. The minimum number of hours per day of active treatment or program services which is specified in each state's policies, regulations, or rules pertinent to mental retardation facilities.

9. The name, address and telephone number of the contact person within the state agency responsible for the residential facilities program.

Definitions. The following definitions were used as part of the survey:

1. Large state-operated residential facility - large group living residence for mentally retarded or otherwise developmentally disabled children and adults operated under state auspice, providing long term care and staffed by shift employees on a 24-hour basis.

2. Facility staff categories - four facility staff groupings were employed:

   a) administration - staff responsible for administering the daily operations of the facility and their staffs, including the facility director, secretarial staff, clerical help and facility management personnel.

   b) clinical - professional staff inclusive of physicians, registered nurses, licensed practical nurses, occupational therapists, recreational therapists, vocational therapists, speech and hearing therapists, psychologists, social workers, teachers and others, and assistants to such professionals.

   c) direct care - staff responsible for the on-unit daily care of residents; referred to variously as therapy aides, unit workers, psychiatric technicians, developmental specialists or ward aides.

   d) support - staff responsible for the upkeep of the facility physical plant and otherwise providing support to the facility, such as maintenance, groundskeeping, housecleaning, laundry, food service, security personnel and vehicle operators.

3. Facility certification - whether the facilities in a state are operated according to the regulations of and are certified under

ICF/MR standards, ACMRDD standards, or some other accepted federal, national, or state standards.

4. Staffing ratios - the computed comparison, in ratio form, of the number of staff to the number of residents for each of the staff categories (administration, clinical, direct care, support) and total number of staff to total number of residents.

5. Programming standard - the minimum number of hours per day of programming which is specified for each individual in a state's facilities as per federal or state guidelines.

Limitations of the Data. The survey team requested that the number of staff be reported in full time equivalents (FTE), however, in a few instances states were unable to report numbers in this fashion. Therefore, for these states the actual number of staff employees were used. Further, data were requested on occupied positions, rather than budgeted positions (the latter would include unoccupied positions) and community services staff employed by facilities were consistently excluded from analyses. The number of contract staff varies from state to state and the manner in which these numbers were reported may also vary. Numbers of contract staff are included within the staff figures for some states and not for others, depending on the accessibility of this information in each state. Likewise, some states may use proportionately larger or smaller numbers of contract staff, thus the basis for reported staffing ratios and the ratios will vary accordingly across states.

Not all states were able to report information on staff using the survey categories and a few states were unable to separate certain job titles into the survey categories. This may affect the categorized staffing ratios but will not affect the overall total staff to resident ratio for any state.

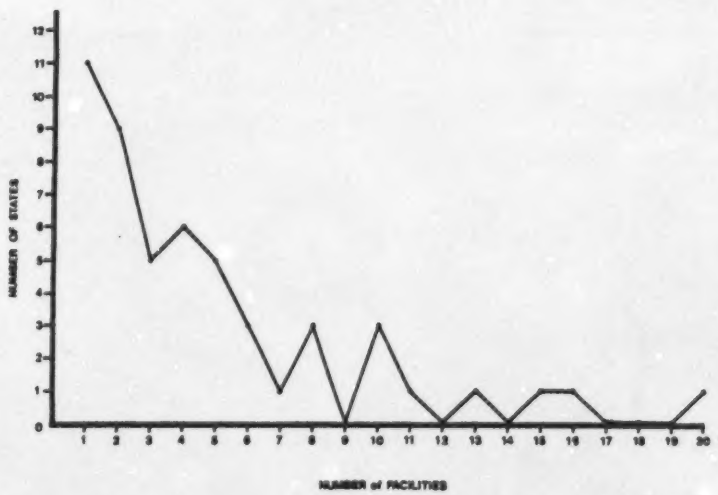
The number of residents per 10,000 may vary when compared across states because of use of community residences, private residential facilities, or other forms of residential care to greater or lesser extents in different states.

The public, quotable records of each state as they were given to the interviewers were accepted as reliable statements and no verifications of data were made.

Results

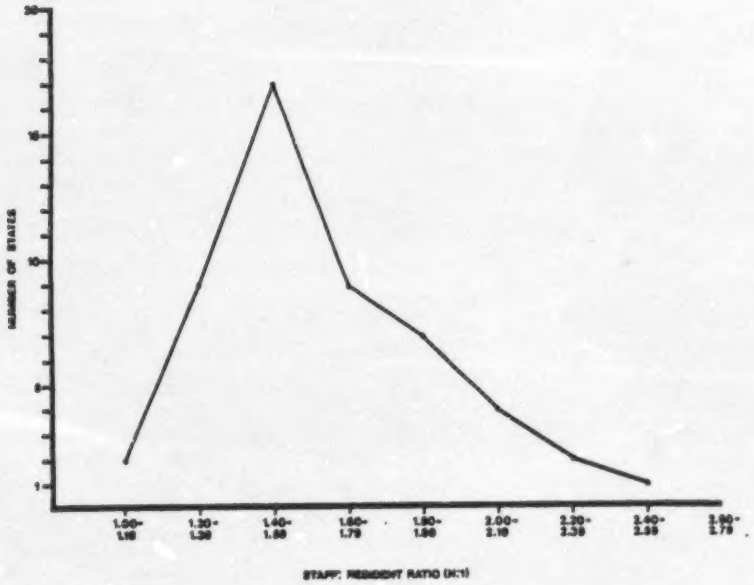
The survey results show that all states have public residential facilities for mentally retarded and developmentally disabled persons (inclusive of combined mental health/mental retardation facilities) (Table 1). There is a total of 247 such facilities nationally with a range of from one facility in 11 states to 20 facilities in New York (Figure 1).

FIGURE 1: Number of Public Residential Facilities Per State



A total of 111,311 persons were reported to be residing in these facilities nationally (a national bed utilization rate of 4.92 per 10,000 general population) (Figure 2). Nationally, such facilities are present at a rate equal to 1 facility per 917,000 general population. A total of 177,719 staff work in public residential facilities, which, when compared with the number of residents in these facilities provides a national staff to resident ratio of 1.60:1 (Figure 3).

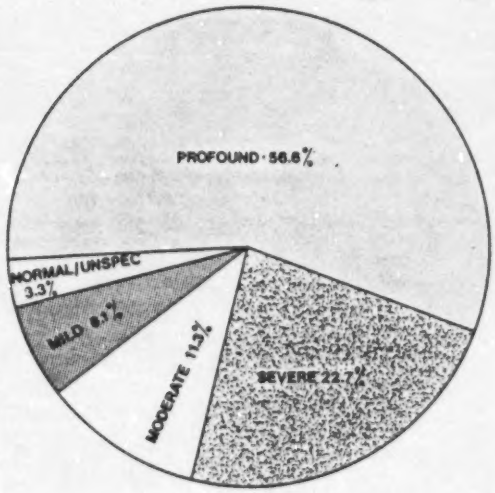
FIGURE 3: Overall Staff: Resident Ratio for All States



Facility certification. Of the total 247 facilities, 233 (94.3%) are at least partially certified as ICF/MR, 47 (19.0%) facilities are ACMRDD certified, and 10 (4.1%) facilities operate under some other form of certification (Table 3). All states except three have at least one ICF/MR-certified facility. Nationally, a total of 36 states have 100% of their public residential facility beds ICF/MR certified. Nationally 92.4% of the facility beds are ICF/MR certified.

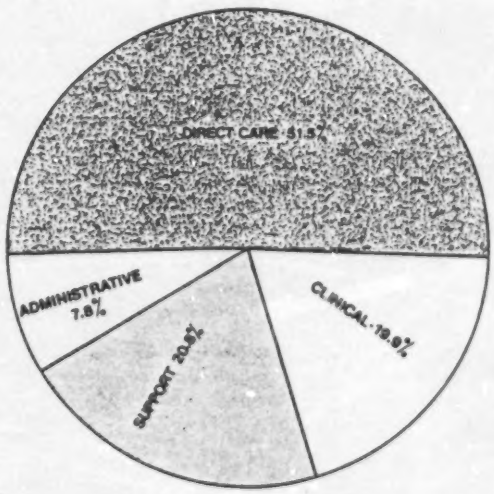
Residents' functional level. With 111,311 residents living in 247 public residential facilites, the average facility size is 450.7 residents per facility. The total number of residents in any one state ranges from 87 in Alaska's one facility to 11,747 in New York's 20 facilities (Table 1). The functional level of residents is fairly stable across all states with a few outliers; of the residents nationally, 50,962 (56.6%) are profoundly retarded, with a low of 41.6% in North Dakota and a high of 75.9% in Hawaii. There are 20,440 (22.7%) severely retarded residents nationally, with a low of 7.6% in Montana and a high of 36.2% in Vermont. Moderately retarded persons account for 10,149 (11.3%) of the total nationally, with Maine having the lowest percentage (4.0%) and North Dakota having the highest percentage (19.7%). Nationally, there are 5,483 (6.1%) mildly retarded residents with a low of 1.0% in New Mexico and Rhode Island and a high of 15.7% in Oklahoma. There are a total of 2956 (3.3%) persons with normal or unspecified intelligence nationally with a low of 0.0% in 16 states and a high of 5.7% in Wyoming (Figure 4).

FIGURE 4: Per Cent of Residents in Public Residential Facilities by Functional Level



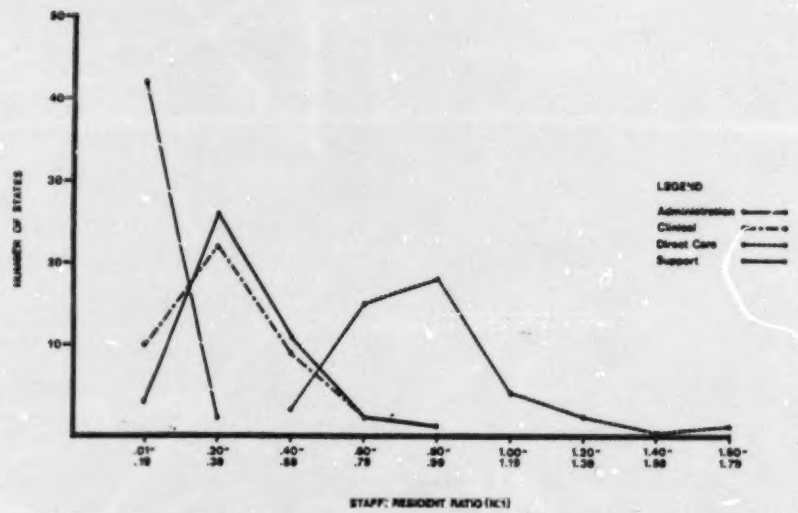
Staff:resident ratios. Across all states there are 177,719 staff in public residential facilities with an average of 719.5 staff per facility. Total staff were divided into four categories (in states where it was possible to do this) in order to present a clearer picture of staffing patterns (Table 2) (Figure 5).

FIGURE 5: Per Cent of Staff in Public Residential Facilities by Staff Category



Nationally, there are 11,155 administrative staff (7.8% of the total) for a ratio of administrative staff to total residents of 0.12:1 among all states. There are 28,469 clinical staff (19.9% of all staff) for a clinical staff to resident ratio, nationally, of 0.32:1. There are 73,385 direct care staff nationally (51.5% of all staff) for a direct care to resident ratio of 0.82:1. Support staff account for 29,586 (20.8%) of the staff for a support staff to resident ratio of 0.33:1 (Table 4) (Figure 6).

FIGURE 6: Categorical Staff: Resident Ratio for All States



The two most important staff categories for patient care are the clinical and direct care categories. The clinical staff category has a range of from 0.08:1 to 0.80:1 staff per resident with about half the states falling close to the average (0.32:1). The direct care to resident category has a range of from 0.47:1 to 1.67:1 staff per resident with, again, about half the states falling near the average (0.82:1).

Staffing standards. Respondents were asked if their states have an ideal staffing ratio goal which they use as a standard in determining staffing levels. A total of 36 states do not employ specific standards for this purpose (Table 3). Many of these states, however, adhere to the standards set down by organizations such as ACMRDD or use ICF/MR standards and several others rely on the availability of

state funds or criteria based upon individual resident programming needs in determining appropriate staffing levels. Of the 15 states that have a specifically determined numerical staffing ratio goal, 1 is staffed at its projected level, 6 have yet to attain that goal, and 8 have exceeded their standard. These 15 states, when ideal goals are calculated, have exceeded their ideal staffing level goals by an average of .08 staff for each resident.

Programming standards. An attempt was also made to determine if there is a standard in each state for the number of hours of programming per day that is required for residents (Table 3). Twenty five states have no specific standard, although many of these states do report that they follow either ICF/MR or ACMRDD standards or have individualized programming dependent on resident needs. For the 26 states which follow a prescribed hour standard, this entails an average of 5.76 hours of resident programming per day.

Discussion

Essentially, data collected in a national telephone survey of staffing ratios in public mental retardation and developmental disabilities institutional systems show that substantive differences exist in the absolute staffing levels of facilities, and in the relative availability of various categories of personnel (especially direct care and clinical).

In order to determine whether facility or resident characteristics were associated with staffing levels a variety of analyses were conducted. The first analysis compared overall staffing levels in states where programs were 100% ICF/MR certified (N = 36) versus those which were not fully certified (N = 15). Mean staffing ratios within these two categories of facilities were essentially identical. Secondly, intercorrelations were computed for total residents, average residents per facility, overall staffing ratio, ratio of direct care to clinical staff, and percent of residents with profound mental retardation. No significant associations among these variables were observed. Similarly, staff:resident ratios for direct care and clinical staff (combined) were unrelated to either the average number of residents per facility, or to the percent of residents with profound mental retardation. Third, comparisons of average utilization rates, direct care and clinical staff:resident ratios (combined), and

total staff:resident ratios were conducted (t tests) for states with (N=18) and without (N=33) consent decrees. No significant differences in these variables were found based upon presence of a consent decree.

In great part variability in staffing practices probably reflects budgetary constraints related to, or imposed by, each state's economic situation and legislative activity. Counterbalancing these factors are professional attitudes favoring active treatment (and by inference, higher staffing levels to support interventions), standards promulgated both in the ICF/MR regulations and by ACMRDD, and specifications of consent decrees.

Some variability may also be attributed to differing staffing methodologies. A number of respondents provided us with copies of their staffing standards and, while typically referencing ICF/MR or ACMRDD for relevant specific ratios for direct care and selected clinical titles, a great deal of fluidity and discretion were noted in procedures for the allocation of both direct care and clinical staff. Similarly, a number of respondents sent copies of consent decree documents which affected staffing practices and, although uniform in intent to improve care practices, these documents differed in the extent and specificity of staffing directives. Finally, consent decrees vary in their impact upon systemic staffing patterns since some (i.e., Massachusetts, Minnesota) encompass all institutional settings, while others (i.e., New York) are in effect in regard only to certain facilities or residents. In general, staffing methods and consent decree documents emphasized the directing of staff resources to persons with severe or profound mental retardation; or to persons who were children, non-ambulatory, or sensorily impaired.

As shown in Table 1, the majority of residents now residing in public developmental disabilities institutions are severely or profoundly mentally retarded (79.3%), and based upon staffing methodologies available for our review, staff to resident ratios should have correspondingly risen since the 1960's and 1970's when a more diverse, and less seriously impaired, population was typically served in these facilities. (Scheerenberger, 1982) found a 1975-76 breakdown of 44% profound, 30% severe, 16% moderate, and 10% mild; Hill and Bruininks (1981) found a 1977-78 breakdown of 47% profound, 29% severe, 15% moderate, and 8% mild; and Scheerenberger (1982) found a 1980-81 breakdown of

55% profound, 25% severe, 13% moderate, and 7% mild. These compare to the present survey's findings of 57% profound, 23% severe, 11% moderate, and 6% mild.) Some evidence in support of this position is provided by the findings of this survey regarding a clinical staff:client ratio of 0.32:1. Previous studies (Scheerenberger, 1982) provide estimates of 0.12:1 for 1975-76 and 0.26:1 for 1980-81. Similarly, Scheerenberger (1982) reported a 1976 direct care staffing ratio of 0.56:1, whereas the present survey found such staff to be employed at a ratio of 0.82:1.

Reductions in the total occupancy of these programs have continued since 1976, from 154,856 (Scheerenberger 1982) to 111,311 in 1983, an effective drop of 28.1%. These figures compare dramatically to early counts which show a facility population of 4001 (a bed utilization rate of 0.64 per 10,000 population) in 1890 and 34,137 facility residents in 1916 (a utilization rate of 3.37 per 10,000) (Fernald, 1917). The 1983 utilization rate is 4.92 per 10,000. Further comparisons can be made with a recent study of psychiatric hospitals (Schnibbe, 1983) in which a bed utilization rate of 5.0 residents per 10,000 was reported. Nursing homes and skilled nursing facilities were reported (Department of Health and Human Services, 1981) to have bed utilization rates of 57.5 per 10,000 for nursing homes and 11.9 per 10,000 for skilled nursing facilities.

Estimates of the number of facilities in operation do not depict as clear a trend. The number of facilities surveyed ranged from 237 in 1976 (Scheerenberger, 1982) to 252 in 1980 (Krantz, Clumpner, Protegard & Bruininks, 1980), 282 in 1981 (Scheerenberger, 1982), 218 in 1982 (Nevada Department of Human Resources, 1983) (including the addition of facilities in non-respondent states from this report) and 247 in 1983 (this report). Depending upon which study is used to describe the number of contemporary facilities (218 vs. 247), a decrease of 8% or an increase of 4.2% in the number of facilities may be projected since 1976.

Reductions in the average size of facilities have taken place during the period 1976 through 1983. Comparisons of numbers of residents and facilities in each study noted above provide estimates of average sizes ranging from 653.4 in 1976 to 519.6 in 1980, 455.6 in 1981, 497.0 in 1982, and 452.4 in 1983. These reductions probably reflect the larger proportionate changes in numbers of

residents versus the comparative stability of the number of facilities.

Surveys done in other long-term care settings, most notably psychiatric hospitals, nursing homes, and skilled nursing facilities point out the extent of care provided to residents of public residential facilities for the mentally retarded. In a national survey of state and county psychiatric hospitals (Schnibbe, 1983) the staff to resident ratio was found to be 0.63:1 for clinical and direct care staff in 36 states for which information was available. Another national survey (Department of Health and Human Services, 1981) found a staff:resident ratio of 0.50:1 in a 1977 sample of nursing homes and 0.58:1 in a sample of skilled nursing facilities for all staff providing direct health-related services to residents. The comparable ratio reported in the present survey is a clinical and direct care staff:resident ratio of 1.14:1.

In the context of previous studies, the results of the present survey suggest that utilization of large public residential facilities has continued to decrease, that these facilities are each typically serving fewer occupants than in the past, and that staffing of facilities has been intensified over the course of recent years.

It should be noted that the present survey, conducted through telephone interviews, appears to be an effective method for collecting data on global state-wide figures. When compared with previous mail surveys, it can be seen that the present survey verifies the trends pointed out by these other studies. Further, it would appear helpful for more research to be conducted in the areas of staffing and in utilization of public residential facilities. Longitudinal data, consistently collected, can lead to important insights into major trends in institutional programming and becomes even more valuable when combined with comparative data for community settings, another area in need of further staffing and utilization research.

References

Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (1983) Standards for services for developmentally disbled individuals. Washington: Author.

Becker, R.E. (1969) Staffing level and treatment effectiveness. British Journal of Psychiatry, 115, 481-482.

Department of Commerce (1981) 1980 Census of Population: Age, sex, race and Spanish origins of the population by regions, divisions, and states--1980. (PC80-S1-1). Washington: Bureau of the Census.

Department of Health and Human Services (1981) Employees in nursing homes in the United States: 1977 national nursing home survey. Hyattsville, Maryland: National Center for Health Statistics, 14 (25).

Department of Health, Education, and Welfare (1978) Standards for intermediate care facilities for the mentally retarded. Subpart G, section 442.445. Federal Register, September 29, 1978, 43, 45246.

Division of Mental Retardation (1968) Public institutions for the mentally retarded: Trends in caseload, manpower, and expenditures. Washington: Social Rehabilitation Service.

Fernald, W.E. (1917) The growth of provision for the feebleminded in the United States. Mental Hygiene, 1, 34-59.

Hill, B.K., & Bruininks, R.H. (1981) Physical and behavioral characteristics and maladaptive behavior of mentally retarded people in residential facilities. Minneapolis: University of Minnesota, Department of Psychoeducational Studies.

Holland, T.P. (1973) Organizational structure and institutional care. Journal of Health and Social Behavior, 14, 241-251.

Krantz, G.C., Clumpner, J.L., Rotegard, L., & Bruininks, R.H. (1980) Mentally retarded people in state-operated residential facilities: Year ending June 30, 1980. Minneapolis: University of Minnesota, Department of Psychoeducational Studies.

Lasky, D.I. & Dowling, M. (1971) The release rates of state mental hospitals as related to maintenance costs and patient-staff ratio. Journal of Clinical Psychology, 27, 272-277.

Lyons, J.P. & Young, J.P. (1976) A staff allocation model for mental health facilities. Health Services Research, 11, 53-68.

Martin, P.Y. & Segal, B. (1977) Bureaucracy, size and staff expectations for client independence in halfway houses. Journal of Health and Social Behavior, 18, 376-390.

Nevada Department of Human Resources (1983) Study of staff/client ratios in mental retardation facilities. Carson City, Nevada: Division of Mental Hygiene and Mental Retardation.

Scheerenberger, R.C. (1982) Public residential services for the mentally retarded: 1981. Madison, Wisconsin: Central Wisconsin Center for the Developmentally Disabled.

Scheerenberger, R.C. (1982) Public residential services, 1981: Status and trends. Mental Retardation, 20, 210-215.

Schnibbe, H.C. (1983) State mental health program indicators - 1982. Washington: National Association of State Mental Health Program Directors.

FIGURE X: Utilization Rates of Public Residential Facility Beds as of January, 1983

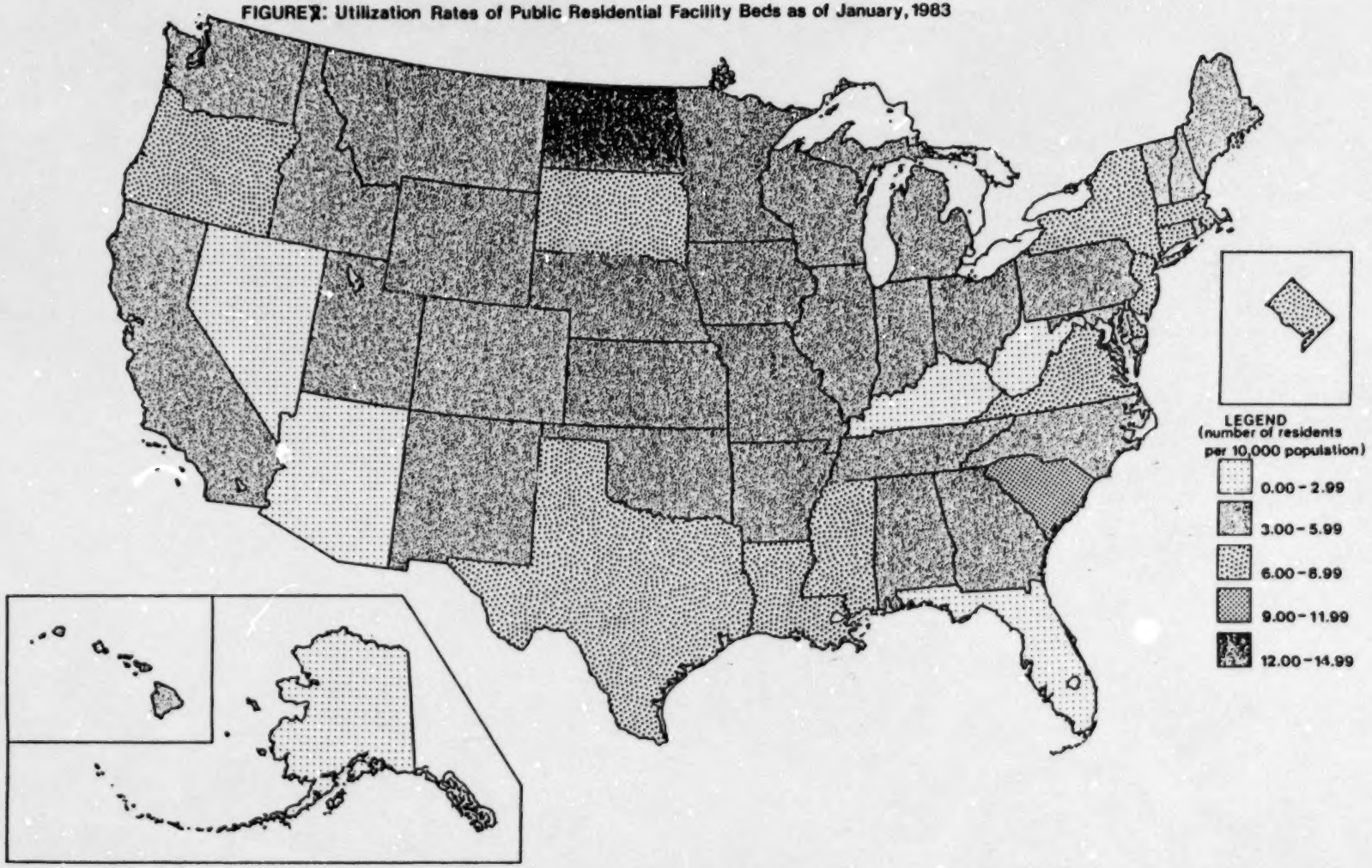


Table 1: Population and Resident Functional Level in Large State Operated Facilities as of January, 1983

State	State Population (X 10,000)	Total Number of Facilities	% of Residents in ICF Beds	Facility Population (Number of Residents/ % of Total) Profound		Severe	Moderate		Mild	Normal/ Unspec.	Total	Number of Residents Per 10,000 Population
Alabama	389.0	4	100.0	853/58.0		369/25.0	197/13.0		47/3.0	16/1.0	1482	3.81
Alaska	40.0	1	100.0	47/54.0		25/28.7	12/13.8		3/3.5	0/0.0	87	2.18
Arizona	271.8	3	0.0	265/47.7		164/29.5	98/17.7		26/4.7	2/0.4	555	2.04
Arkansas	228.6	6	100.0	731/54.0		352/26.0	190/14.0		81/6.0	0/0.0	1354	5.92
California	2366.8	8	100.0	5247/68.0		1235/16.0	617/8.0		309/4.0	309/4.0	7717	3.26
Colorado	288.9	3	100.0	710/63.1		201/17.9	123/10.9		79/7.0	12/1.1	1125	3.89
Connecticut	310.7	2	0.0	1092/52.0		504/24.0	315/15.0		147/7.0	42/2.0	2100	6.76
Delaware	59.5	1	100.0	-		-	-		-	-	520[a]	8.74
Dist. of. Col.	63.8	1	67.0	362/66.1		109/19.9	44/8.0		33/6.0	0/0.0	548	8.59
Florida	973.9	4	56.0	-		-	-		-	-	2232[a]	2.29
Georgia	546.4	6	89.4	-		-	-		-	-	2263[a]	4.14
Hawaii	96.5	1	100.0	281/75.9		52/14.1	26/7.0		11/3.0	0/0.0	370	3.83
Idaho	94.4	1	100.0	244/69.3		69/19.6	20/5.7		13/3.7	6/1.7	352	3.73
Illinois	1141.8	16	89.9	2736/54.9		952/19.1	658/13.2		394/7.9	244/4.9	4984	4.37
Indiana	549.0	4	35.0	1151/57.0		404/20.0	242/12.0		121/6.0	101/5.0	2019	3.68
Iowa	291.3	2	100.0	756/61.0		211/17.0	161/13.0		99/8.0	12/1.0	1239	4.25
Kansas	236.3	4	100.0	776/63.0		209/17.0	136/11.0		111/9.0	0/0.0	1232	5.21
Kentucky	366.1	4	100.0	459/56.0		246/30.0	90/11.0		25/3.0	0/0.0	820	2.24
Louisiana	420.3	8	100.0	1888/56.1		749/22.3	422/12.5		306/9.1	0/0.0	3365	8.01
Maine	112.5	3	100.0	242/64.9		112/30.0	15/4.0		4/1.1	0/0.0	373	3.32
Maryland	421.6	10	75.3	1322/59.0		560/25.0	268/12.0		90/4.0	0/0.0	2240	5.31
Massachusetts	573.7	7	100.0	1674/42.4		1304/33.1	608/15.4		284/7.2	75/1.9	3945	6.88
Michigan	925.8	11	100.0	-		-	-		-	-	2943[a]	3.18
Minnesota	407.7	8	100.0	1304/59.0		575/26.0	177/8.0		111/5.0	44/2.0	2211	5.42
Mississippi	252.0	5	100.0	-		-	-		-	-	1848[a]	7.33
Missouri	491.7	5	100.0	907/48.6		516/27.7	231/12.4		125/6.7	86/4.6	1865	3.79
Montana	78.7	2	100.0	209/75.7		21/7.6	35/12.7		9/3.3	2/0.7	276	3.51
Nebraska	157.0	1	100.0	339/70.0		74/15.3		68/14.1		3/0.6	464[a]	3.08
Nevada	79.9	2	100.0	-		-	-		-	-	172[a]	2.15
New Hampshire	92.1	1	61.4	225/51.1		148/33.7	48/10.9		19/4.3	0/0.0	440	4.78
New Jersey	736.4	10	63.1	3607/55.5		1490/22.9	717/11.0		653/10.1	33/0.5	6500	8.83
New Mexico	130.0	2	100.0	303/60.5		168/33.5	25/5.0		5/1.0	0/0.0	501	3.85
New York	1755.7	20	100.0	6766/57.6		2866/24.4	1151/9.8		682/5.8	282/2.4	11,747	6.69
North Carolina	587.4	5	70.2	2043/63.9		791/24.7	257/8.0		75/2.3	34/1.1	3200	5.45
North Dakota	65.3	2	29.0	399/41.6		271/28.3	189/19.7		100/10.4	0/0.0	959	14.70
Ohio	1079.7	15	100.0	1943/51.0		876/23.0	648/17.0		267/7.0	76/2.0	3810	3.53
Oklahoma	302.5	3	100.0	713/41.5		344/20.0	391/22.8		270/15.7	0/0.0	1718	5.68
Ontario[b]	852.5	1	16.6	1785/32.3		1544/27.9	1106/20.0		903/16.3	190/3.5	5528	6.49
Oregon	263.3	2	100.0	901/56.6		320/20.1	221/13.9		144/9.1	5/0.3	1591	6.04
Pennsylvania	1186.7	10	100.0	3365/57.8		1493/25.7	566/9.7		222/3.8	176/3.0	5822[c]	4.91
Rhode Island	94.7	1	100.0		414/93.0		27/6.0		4/1.0	0/0.0	445[a]	4.70
South Carolina	311.9	4	94.7	1697/60.3		605/21.5	290/10.3		155/5.5	69/2.4	2816	9.03
South Dakota	69.0	2	100.0	439/72.8		100/16.6	39/6.5		12/2.0	13/2.1	603	8.74
Tennessee	459.1	5	98.5	1456/66.9		369/17.0	185/8.5		130/6.0	35/1.6	2175	4.74
Texas	1422.8	13	100.0	-		-	-		-	-	9007[a]	6.33
Utah	146.1	1	100.0		729/97.3		0/0.0		20/2.7	0/0.0	749[a]	5.13
Vermont	51.1	1	100.0	89/43.0		75/36.2	32/15.5		11/5.3	0/0.0	207	4.05
Virginia	534.6	5	100.0	1880/54.9		895/26.2	464/13.6		142/4.1	41/1.2	3422	6.40
Washington	413.0	6	100.0	-		-	-		-	-	1875[a]	4.54
West Virginia	195.0	2	32.5	-		-	-		-	-	461[a]	2.36
Wisconsin	470.5	3	100.0	1277/60.8		582/27.7	147/7.0		93/4.4	2/0.1	2101	4.47
Wyoming	94.7	1	100.0	264/59.9		34/7.7	67/15.2		51/11.5	25/5.7	441	4.66
Total/Average	22,649.7	247	92.4	50,962/56.6	1143/1.3	20,440/22.7	10,149/11.3	68/0.1	5483/6.1	1745/1.9	111,311	4.92

a - Indicates total facility population not easily broken into MR functional level
b - Ontario included for comparative purposes: Numbers not used in computing column totals
c - Does not include 820 residents in 7 units and 1 center with substantial mixed MH-MR staff and other staff unable to be counted

Table 2: Staff and Staffing Ratios of Large State Operated Facilities as of January, 1983

State	Number of Facility Staff: Administrative	Clinical	Direct Care	Support	Total	Staff : Resident Ratio
Alabama	174	284	1812	382	2652	1.79:1
Alaska	14	7	66	52	139	1.60:1
Arizona	157	156	555	220	1088	1.96:1
Arkansas	-	..	-	-	2437[b]	1.80:1
California	1052	2634	5277	2516	11,479	1.49:1
Colorado	136	134	845	221	1336	1.19:1
Connecticut	268	534	1702	531	3035	1.45:1
Delaware	39	181	244	162	626	1.20:1
Dist. of Col.	96	214	400	207	917	1.67:1
Florida	198	1391	2439	99	4127	1.85:1
Georgia	-	-	-	-	4848[b]	2.14:1
Hawaii	43	88	313	122	566	1.53:1
Idaho	25	120	295	120	560	1.59:1
Illinois	299	1131	4342	1820	7592	1.52:1
Indiana	239	532	1355	762	2888	1.43:1
Iowa	177	560	1159	411	2307	1.86:1
Kansas	351	235	916	486	1988	1.61:1
Kentucky	57	86	879	259	1281	1.56:1
Louisiana	473	792	2618	1551	5434	1.62:1
Maine	47	184	412	172	815	2.19:1
Maryland	214	700	1464	520	2898	1.29:1
Massachusetts	758	3152	3881	2241	10,032	2.54:1
Michigan	250	675	2036	1329	4290	1.46:1
Minnesota	-	909	1996	-	3481[b]	1.57:1
Mississippi	326	-	-	-	2605[b]	1.41:1
Missouri	268	852	1810	908	3838	2.06:1
Montana	20	114	244	198	576	2.09:1
Nebraska	84	82	574	194	934	1.93:1
Nevada	24	53	171	16	264	1.54:1
New Hampshire	66	273	560	109	1008	2.29:1
New Jersey	964	1577	4165	2031	8737	1.34:1
New Mexico	30	199	407	213	849	1.70:1
New York	1485	4338	10,718	5416	21,957	1.87:1
North Carolina	-	4219		-	5612[b]	1.75:1
North Dakota	41	148	797	193	1179	1.23:1
Ohio	-	-	-	-	6569[b]	1.72:1
Oklahoma	157	391	1185	470	2203	1.28:1
Ontario[a]	717	1382	3631	1785	7515	1.36:1
Oregon	219	122	807	576	1724	1.08:1
Pennsylvania	-	-	-	-	9004[b]	1.55:1
Rhode Island	25	210	356	237	832	1.87:1
South Carolina	174	979	2350	840	4343	1.54:1
South Dakota	34	223	358	247	862	1.43:1
Tennessee	351	279	2066	601	3297	1.52:1
Texas	975	1531	7510	1105	11,121	1.24:1
Utah	78	245	466	143	932	1.25:1
Vermont	33	68	345	44	490	2.37:1
Virginia	458	3245		928	4631[b]	1.35:1
Washington	-	830	1384	-	2768[b]	1.48:1
West Virginia	76	122	412	154	764	1.66:1
Wisconsin	155	1008	1416	679	3258	1.55:1
Wyoming	41	126	278	101	546	1.24:1
Total/Average	11,155	28,469	7464 73,385	29,586	177,719	1.60:1

a - Ontario included for comparative purposes: Numbers not used in computing column totals

Table 3: Staffing and Programming Standards For Large State Operated Facilities as of January, 1983

State	Total Number of Facilities	Facility Certification (Number of Facilities) ICFMR	ACMRDD	OTHER	% of Residents in ICF Beds	Ideal Staffing Ratio Goal (Staff:Resident)	Actual Overall Staff:Resident Ratio	Programming Standard (Minimum Hrs./Day)
Alabama*	4	4	0	0	100.0	1.75:1	1.79:1	-
Alaska	1	1	0	0	100.0	-	1.60:1	-
Arizona*	3	0	2	1	0.0	1.00:1 (direct care)	1.96:1	hrs./day
Arkansas	6	6	1	0	100.0	-	1.80:1	-
California	8	8	6	0	100.0	1.41:1	1.49:1	8 hrs./day
Colorado	3	3	0	0	100.0	-	1.19:1	6 hrs./day
Connecticut*	2	0	0	2	0.0	-	1.45:1	-
Delaware	1	1	0	0	100.0	1.50:1	1.20:1	5.5 hrs./day
Dist. of Col.*	1	1	0	0	67.0	-	1.67:1	5 hrs./day
Florida*	4	4	0	0	56.0	-	1.85:1	6 hrs./day
Georgia	6	6	3	0	89.4	1.223:1	2.14:1	-
Hawaii	1	1	0	0	100.0	-	1.53:1	-
Idaho	1	1	0	0	100.0	1.00:1	1.59:1	4.38 hrs./day
Illinois	16	14	10	2	89.9	1.60:1	1.52:1	-
Indiana	4	1	0	3	35.0	1.00:1 (direct care)	1.43:1	-
Iowa	2	2	0	0	100.0	2.00:1	1.86:1	5 hrs./day
Kansas	4	4	0	0	100.0	-	1.61:1	6 hrs./day
Kentucky	4	4	0	0	100.0	-	1.56:1	-
Louisiana*	8	8	0	0	100.0	-	1.62:1	ICF-MR
Maine*	3	2	0	0	100.0	2.19:1	2.19:1	6 hrs./day
Maryland	10	10	1	0	75.3	-	1.29:1	-
Massachusetts*	7	7	0	0	100.0	-	2.54:1	6 hrs./day
Michigan*	11	11	3	0	100.0	1.87:1	1.46:1	5 hrs./day
Minnesota*	8	8	3	0	100.0	-	1.51:1	6 hrs./day
Mississippi	5	5	0	0	100.0	-	1.41:1	-
Missouri	5	5	1	0	100.0	2.00:1	2.06:1	5 hrs./day
Montana	2	2	0	0	100.0	-	2.09:1	5 hrs./day
Nebraska*	1	1	0	0	100.0	availability of funds	1.93:1	-
Nevada	2	2	0	0	100.0	Title 19, ACMRDD	1.54:1	6 hrs./day
New Hampshire	1	1	0	0	61.4	-	2.29:1	5.25 hrs./day
New Jersey	10	10	0	0	63.1	-	1.34:1	5 hrs./day
New Mexico	2	2	0	0	100.0	availability of funds	1.70:1	5-7.5 hrs./day
New York*	20	20	1	0	100.0	1.78:1	1.87:1	6 hrs./day
North Carolina	5	5	1	0	70.2	type of programming	1.75:1	individualized
North Dakota*	2	2	0	0	29.0	ACMRDD	1.23:1	ICF-MR, ACMRDD
Ohio	15	15	3	0	100.0	Medicaid Standards	1.72:1	individualized
Oklahoma	3	3	0	0	100.0	ICF-MR	1.28:1	ICF-MR
Ontario	16	-	-	-	-	AAMD	1.36:1	AAMD Standards
Oregon	2	2	0	0	100.0	-	1.08:1	5 hrs./day
Pennsylvania*	10	10	2	0	100.0	individualized	1.55:1	individualized
Rhode Island	1	1	0	0	100.0	2.00:1	1.87:1	5 hrs./day
South Carolina	4	4	0	0	94.7	individualized	1.54:1	individualized
South Dakota	2	2	0	0	100.0	2.00:1	1.43:1	individualized
Tennessee*	5	4	5	0	98.5	-	1.52:1	-
Texas*	13	13	1	0	100.0	individualized	1.24:1	individualized
Utah*	1	1	0	0	100.0	ICF-MR	1.24:1	6 hrs./day
Vermont	1	1	0	0	100.0	availability of funds	2.37:1	6 hrs./day
Virginia	5	5	4	0	100.0	national average	1.35:1	Title 19, ACMRDD
Washington	6	6	0	0	100.0	-	1.48:1	5 hrs./day
West Virginia*	2	1	0	1	32.5	-	1.66:1	9 hrs./day
Wisconsin	3	3	0	0	100.0	-	1.55:1	ICF-MR.
Wyoming	1	0	0	1	0.0	ICF-MR	1.24:1	ICF-MR
Total	247	233	47	10	92.4		1.60:1	

a - Ontario included for comparative purposes: Numbers not used in computing column totals

* - Indicates states having a consent decree or judgement in effect at the time of the survey

Table 4: Staff:Resident Ratios of Large State Operated Facilities as of January, 1983

State	Total Facility Population	Total Facility Staff	Total Staff:Resident Ratio	Staff:Resident Ratios by Staff Category			
				Administration:Resident Ratio	Clinical:Resident Ratio	Direct Care:Resident Ratio	Support:Resident Ratio
Alabama	1482	2652	1.79:1	.12:1	.19:1	1.22:1	.26:1
Alaska	87	139	1.60:1	.16:1	.08:1	.76:1	.60:1
Arizona	555	1088	1.96:1	.28:1	.28:1	1.00:1	.40:1
Arkansas	1354	2437	1.80:1				
California	7717	11,479	1.49:1	.14:1	.34:1	.68:1	.33:1
Colorado	1125	1336	1.19:1	.12:1	.12:1	.75:1	.20:1
Connecticut	2100	3035	1.45:1	.13:1	.25:1	.81:1	.25:1
Delaware	520	626	1.20:1	.08:1	.35:1	.47:1	.31:1
Dist. of Col.	548	917	1.67:1	.18:1	.39:1	.73:1	.38:1
Florida	2232	4127	1.85:1	.09:1	.62:1	1.09:1	.04:1
Georgia	2263	4848[a]	2.14:1				
Hawaii	370	566	1.53:1	.12:1	.24:1	.85:1	.33:1
Idaho	352	560	1.59:1	.07:1	.34:1	.84:1	.34:1
Illinois	4984	7592	1.52:1	.06:1	.23:1	.87:1	.37:1
Indiana	2019	2888	1.43:1	.12:1	.26:1	.67:1	.38:1
Iowa	1239	2307	1.86:1	.14:1	.45:1	.94:1	.33:1
Kansas	1232	1988	1.61:1	.29:1	.19:1	.74:1	.40:1
Kentucky	820	1281	1.56:1	.07:1	.11:1	1.07:1	.32:1
Louisiana	3365	5434	1.62:1	.14:1	.24:1	.78:1	.46:1
Maine	373	815	2.19:1	.13:1	.49:1	1.11:1	.46:1
Maryland	2240	2898	1.29:1	.10:1	.31:1	.65:1	.23:1
Massachusetts	3945	10,032	2.54:1	.19:1	.80:1	.98:1	.57:1
Michigan	2943	4290	1.46:1	.09:1	.23:1	.69:1	.45:1
Minnesota	2211	3481[a]	1.57:1		.41:1		
Mississippi	1848	2605[a]	1.41:1	.18:1		.90:1	
Missouri	1865	3838	2.06:1	.14:1	.46:1	.97:1	.49:1
Montana	276	576	2.09:1	.07:1	.41:1	.88:1	.72:1
Nebraska	484	934	1.93:1	.17:1	.17:1	1.19:1	.40:1
Nevada	172	264	1.54:1	.14:1	.31:1	.99:1	.09:1
New Hampshire	440	1008	2.29:1	.15:1	.62:1	1.27:1	.25:1
New Jersey	6500	8737	1.34:1	.15:1	.24:1	.64:1	.31:1
New Mexico	501	849	1.70:1	.06:1	.40:1	.81:1	.43:1
New York	11,747	21,957	1.87:1	.13:1	.37:1	.91:1	.46:1
North Carolina	3200	5612[a]	1.75:1			1.32:1	
North Dakota	959	1179	1.23:1	.04:1	.15:1	.83:1	.20:1
Ohio	3810	6569[a]	1.72:1				
Oklahoma	1718	2203	1.28:1	.09:1	.23:1	.69:1	.27:1
Ontario[b]	5528	7515	1.36:1	.13:1	.25:1	.66:1	.32:1
Oregon	1591	1724	1.08:1	.14:1	.08:1	.51:1	.36:1
Pennsylvania	5822	9004[a]	1.55:1				
Rhode Island	445	832	1.87:1	.07:1	.47:1	.80:1	.53:1
South Carolina	2816	4343	1.54:1	.06:1	.35:1	.84:1	.30:1
South Dakota	603	862	1.43:1	.06:1	.37:1	.59:1	.41:1
Tennessee	2175	3297	1.52:1	.16:1	.13:1	.95:1	.28:1
Texas	9007	11,121	1.24:1	.11:1	.17:1	.83:1	.12:1
Utah	749	932	1.24:1	.10:1	.33:1	.62:1	.19:1
Vermont	207	490	2.37:1	.16:1	.33:1	1.67:1	.21:1
Virginia	3422	4631[a]	1.35:1	.13:1		.95:1	.27:1
Washington	1875	2768[a]	1.48:1		.44:1	.74:1	
West Virginia	461	764	1.66:1	.17:1	.27:1	.89:1	.33:1
Wisconsin	2101	3258	1.55:1	.07:1	.48:1	.67:1	.32:1
Wyoming	441	546	1.24:1	.09:1	.29:1	.63:1	.23:1
Total	111,311	177,719	1.60:1	.12:1	.32:1	1.13:1 .82:1	.33:1

a - Indicates total facility staff not easily broken into survey categories

b - Ontario included for comparative purposes: Numbers not used in computing column totals

Appendix A

Persons Contacted Representing
State Agencies Responsible for Public Residential Facilities for
Mentally Retarded/Developmentally Disabled Persons

Alabama

Alabama State Dept. of Mental Health
200 Interstate Park Drive
Box 3710
Montgomery, Alabama 36913-5001

Dr. Allen Marchetti
(205) 271-9292

Alaska

Harborview D.C.
P.O. Box 487
Valdey, Alaska 99686-0487

Pat Lando
(907) 835-4344

Arizona

Arizona DES-DDD
P.O. Box 6760
Phoenix, Arizona 85005

Dan Scott
(602) 255-5775

Arkansas

Arkansas Dept. of Human Services
Developmental Disabilities Services
Suite 400, Waldon Building
7th and Main Sts.
Little Rock, Arkansas 72201

Ray Nelson
(501) 371-3419

California

California Dept. of Developmental Services
Hospital Operations Division
1600 9th St.
Sacramento, California 95814

Clara Cargile
(916) 323-7882

Colorado

Colorado Division for Developmental Disabilities
3824 West Princeton Circle
Denver, Colorado 80236

Don Weaver
(303) 761-5990

Connecticut

Connecticut Dept. of Mental Retardation
342 N. Main St.
West Hartford, Connecticut 06117

Scott Bell
(203) 236-2531 Ext. 254

Delaware

Stockley Center
Rt. 1, Box 1000
Georgetown, Delaware 19947

Tim Wilson
(302) 934-8031 Ext. 218

District of Columbia

District of Columbia Dept. of
Human Services
CSS/MRDDA
Bureau of Habilitation Services
3600 Center Ave.
Laurel, Maryland 20707

Donald C. Brooks
(301) 725-3600 Ext. 2870

Florida

Florida Dept. of Health &
Rehabilitation Services
Developmental Services Program Office
1311 Winewood Blvd.
Tallahassee, Florida 32301

Margaret Hargrove
(904) 488-3673

Georgia

Georgia Dept. of Human Resources
Division of MH & MR
47 Trinity Ave., S.W.
Atlanta, Georgia 30334

Betty Goodwin
(404) 656-7011

Hawaii

Waimano Training School & Hospital
Pearl City, Hawaii 96872

Willson Salcai
(808) 456-6239

Idaho

Idaho State School & Hospital
3100 11th Ave., North
Nampa, Idaho 83651

Dr. Daniel Fazzini
(208) 466-9255

Illinois

Illinois Dept. of Mental Health &
Developmental Disabilities
Room 402
Stanton Office Building
Springfield, Illinois 62706

Judy Redick
(217) 782-7393

Indiana

Indiana Dept. of Mental Health
429 No. Pennsylvania St.
Indianapolis, Indiana 46204

Edward Taylor
(317) 232-7867

Iowa

Iowa Dept. of Social Services
Division of MH/MR/DD
Hoover State Office Building
Des Moines, Iowa 50319

Harold Templeman
(515) 281-5126

Kansas

Kansas Dept. of Social &
Rehabilitation Services
Division of Mental Retardation
5th Floor
State Office Building
Topeka, Kansas 66612

R. Dan Horner
(913) 296-3773

Kentucky

Kentucky Dept. for Health Services
Division for Institutional Care
275 East Main Street
Frankfort, Kentucky 40601

Dorothy Schrader
(502) 564-7700